



CHILDREN'S ADMINISTRATION
ADOPTION SUPPORT PROGRAM
CHILD'S REGISTRATION

CHILD'S LEGAL NAME (LAST, FIRST, MIDDLE)					BIRTHDATE		FOR OFFICIAL USE ONLY Source of funding: IVE _____ SO _____ Other resources: <div style="display: flex; justify-content: space-around; font-size: small;">YES NO</div> <table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 30%;">DDD</td><td style="width: 30%;"></td><td style="width: 30%;"></td></tr><tr><td>SSI</td><td></td><td></td></tr><tr><td>SSA</td><td></td><td></td></tr></table> Family Insurance: _____		DDD			SSI			SSA																
DDD																															
SSI																															
SSA																															
SEX <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Male<input type="checkbox"/> Female</div>					ETHNIC BACKGROUND																										
ADOPTIVE FAMILY'S NAME (PLEASE PRINT OR TYPE)																															
LEGAL STATUS																															
	TERMIN- ATION	RELIN- QUISH- MENT	DEATH	DATE	DECREE NUMBER	COUNTY AND STATE																									
Mother																															
Father																															
Other (specify):																															
A. GENERAL DIAGNOSTIC STATEMENT. BRIEFLY STATE CHILD'S SOCIAL HISTORY AND CURRENT FUNCTIONING. USE THE BACK OF THIS FORM IF NECESSARY.							COMMENTS																								
B. PLAN <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Relative adoption <input type="checkbox"/> Foster/adoptive home <input type="checkbox"/> Foster parent adoption <input type="checkbox"/> Adoptive home</div><div style="width: 20%; text-align: center; font-size: small;">DATE CHILD ENTERED FOSTER CARE</div><div style="width: 20%; text-align: center; font-size: small;">DATE OF CURRENT PLACEMENT</div></div>					TOTAL NUMBER PLACEMENTS				CURRENT FOSTER CARE PAYMENTS																						
c. Reasonable efforts or against best interest to search for placement (WAC 388-27-0145 and 388-27-0150) <input type="checkbox"/> Child registered for 3 months with WARE without finding an adoptive family <input type="checkbox"/> A documented formal search was conducted without finding a family who would adopt the child without adoption support <input type="checkbox"/> Selected prospective adoptive family is unable to adopt without assistance from the adoption support program <input type="checkbox"/> Not in best interest of the child to search for a family due to circumstances of current placement					D. SPECIAL NEEDS CONDITIONS OF THE CHILD (CHECK ALL THAT APPLY) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> 1. Race <input type="checkbox"/> 2. Age (6+years) <input type="checkbox"/> 3. Sibling group <input type="checkbox"/> 4. Emotional problems* <input type="checkbox"/> 5. Physical problems* <input type="checkbox"/> 6. Significant developmental delays* <small>* ATTACH ANY MEDICAL AND/OR PSYCHIATRIC EVALUATIONS OR OTHER REPORTS WHICH DOCUMENT THE CHILD'S IDENTIFIED SPECIAL NEEDS CONDITION(S)</small></div><div style="width: 20%; text-align: center; font-size: small;">DOCUMENTED</div><div style="width: 20%; text-align: center; font-size: small;">BARRIER</div></div> <table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 10%; text-align: center; font-size: x-small;">YES</td><td style="width: 10%; text-align: center; font-size: x-small;">NO</td><td style="width: 10%; text-align: center; font-size: x-small;">YES</td><td style="width: 10%; text-align: center; font-size: x-small;">NO</td></tr><tr><td style="height: 20px;"></td><td></td><td></td><td></td></tr><tr><td style="height: 20px;"></td><td></td><td></td><td></td></tr><tr><td style="height: 20px;"></td><td></td><td></td><td></td></tr><tr><td style="height: 20px;"></td><td></td><td></td><td></td></tr><tr><td style="height: 20px;"></td><td></td><td></td><td></td></tr></table>				YES	NO	YES	NO																			
YES	NO	YES	NO																												
E. REASON FAMILY REQUESTING ADOPTION SUPPORT PAYMENT/SERVICES. IF ADDITIONAL SPACE IS NECESSARY, USE THE BACK OF FORM.							Cash payment per month: _____ Supplement per month: _____ <input type="checkbox"/> This child has been determined hard to place with special needs and is APPROVED for Adoption Support services. <input type="checkbox"/> This child is NOT APPROVED for Adoption Support.																								
WORKER'S NAME					TELEPHONE NUMBER																										
DIVISION OF CHILDREN AND FAMILY SERVICES OFFICE OR CHILD PLACING AGENCY NAME																															
WORKER'S SIGNATURE					DATE		PROGRAM MANAGER'S SIGNATURE																								
DIVISION OF CHILDREN AND FAMILY SERVICES OFFICE OR CHILD PLACING AGENCY ADDRESS					DATE																										